



## **Texas Department of Insurance**

### **Division of Workers' Compensation**

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### **GENERAL INFORMATION**

#### **Requestor Name and Address**

TEXAS HEALTH OF PLANO  
3255 WEST PIONEER PARKWAY  
ARLINGTON TEXAS 76013

#### **Respondent Name**

Hartford Fire Insurance Co

#### **Carrier's Austin Representative Box**

Box Number 47

#### **MFDR Tracking Number**

M4-12-3322-01

#### **MFDR Date Received**

July 11, 2012

### **REQUESTOR'S POSITION SUMMARY**

**Requestor's Position Summary:** "We submitted appeals with the emails from Sedgwick, from the adjuster and also the team lead in bill review showing they state no authorization was needed."

**Amount in Dispute:** \$4,255.88

### **RESPONDENT'S POSITION SUMMARY**

**Respondent's Position Summary:** Written acknowledgement of medical fee dispute was received however, no response submitted.

### **SUMMARY OF FINDINGS**

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
July 12, 2011	Outpatient Hospital Services	\$4,255.88	\$0.00

### **FINDINGS AND DECISION**

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403, titled *Hospital Facility Fee Guideline – Outpatient*, sets out the reimbursement guidelines for facility services provided in an outpatient acute care hospital.
3. 28 Texas Administrative Code §134.600 sets out the guidelines for prospective review of health care.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - 197 – Payment adjusted for absence of precert/preauth
  - RN – Not paid under OPPS; services included in APC rate
  - B15 – Procedure/Service is not paid separately

### Issues

1. Does the submitted documentation support the insurance carrier's reason for denying submitted charges?
2. Is the requestor entitled to reimbursement?

### Findings

1. The insurance carrier denied disputed services with reason code 197 – Payment adjusted for absence of precert/preauth. Per 28 Texas Administrative Code §134.600(c)(1), effective May 2, 2006, 31 *Texas Register* 3566, the carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) only in the care of an emergency or "preauthorization of any health care listed in subsection (p)... that was approved prior to providing health care." §134.600(p)(2) states that the non-emergency health care requiring preauthorization includes "outpatient surgical or ambulatory surgical services." Documentation was not found to support that this surgical service had been preauthorized. The insurance carrier's denial reason is supported. The Division therefore concludes that the denial reason is supported. Reimbursement is not recommended.
2. The service in dispute was not prior authorized as required by Texas Administrative Code. No reimbursement can be recommended

### Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### **ORDER**

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### Authorized Signature

_____	_____	September 23, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

### **YOUR RIGHT TO APPEAL**

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**